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OPERATING FRANCES NELSON AND SMILEHEALTHY

Adult Patient Health History

Please complete both sides of form

This questionnaire is used to collect information about your current health history. In addition to providing your health care team with important clinical information, this questionnaire also helps us meet special requirements established by Medicare and other health insurers.

Patient Information:

Name: _____ Date of Birth: _____/_____/____ Birthplace: _____

Religion: _____ (If you choose to disclose) Gender at Birth: □Male □Female

What is your primary language? _____

Primary Care/Family Physician's Name: _____

City: _____

Allergies:

Have you had hives, skin rash, breathing problems or other allergic reactions to medications? □Yes □No

If yes, please list below:

Name of medicine(s): _____
Describe allergic reaction:
_____

Are there medications, other than those you are allergic to, you would prefer not to take due to prior unpleasant side effects? □Yes □No If yes, please specify:
_____

Have you had allergic reaction to:

- Iodine or x-ray contrast dye? □Yes □No
- Latex or rubber (gloves, condoms, balloons)? □Yes □No
- Shellfish? □Yes □No
- Bee or wasp stings? □Yes □No
- Adhesive tape? □Yes □No
- Other allergies (specify): _____
- List any food allergies: □None
  _____

Height: _____ Weight: _____ Date of last Flu shot: _____ /_____ /_____

Recent weight change? □No □Yes Gain of _____ lbs. Loss of _____ lbs.

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Past Medical history:

Check if you have or have had any of the following:

□ Allergies
□ Cerebrovascular accident
□ Hypertension
□ Anemia
□ COPD
□ Irritable bowel disease
□ Angina
□ Coronary artery disease
□ Migraine headaches
□ Arthritis
□ Depression
□ Anxiety
□ Myocardial infarction
□ Asthma
□ Diabetes
□ Osteoarthritis
□ Atrial fibrillation
□ Gallbladder disease
□ Osteoporosis
□ Benign prostatic hypertrophy
□ GERD
□ Peptic ulcer disease
□ Blood clots
□ Hepatitis C
□ Renal disease
□ Cancer
□ Hyperlipidemia
□ Chron's disease
□ Liver disease
□ Seizure disorder (type:_____)
□ Thyroid disease
□ Other (specify):_____

Past surgical history:

Please check all that applies:

	Year		Year		Year
☐ Angioplasty	_____	☐ Colectomy	_____	☐ Pacemaker	_____
☐ Angio with Stent	_____	☐ Colostomy	_____	☐ Prostate Biopsy	_____
☐ Appendectomy	_____	☐ Gastric Bypass	_____	☐ Small Bowel Resection	_____
☐ Arthroscopy	_____	☐ Hernia Repair	_____	☐ Thyroidectomy	_____
☐ Back Surgery	_____	☐ Hip Replacement	_____	☐ Tonsillectomy	_____
☐ CABG	_____	☐ Knee Replacement	_____	☐ TURP	_____
☐ Carpal Tunnel	_____	☐ LASIK	_____	☐ Vasectomy	_____
☐ Cataract Extraction	_____	☐ Liver Biopsy	_____	☐ Other: _____	_____
☐ Cholecystectomy	_____	☐ ORIF	_____	☐ Other: _____	_____

Hospitalizations: Please list past major hospitalizations:

Year:	Place:	Illness/Injury Doctor:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Exercise:

□Yes □No How often do you exercise?_____

What type of exercise (walking, running, swimming)? _____

Coffee:

Do you drink coffee? □Yes □No How many cups of coffee do you drink in a day? _____

Tobacco:

Do you currently use tobacco? □Yes □No How many years have you used tobacco regularly? _____

What form of tobacco do you currently use? (cigarettes, pipe, cigar, chew)? _____

Do you use any other nicotine products (e-cigarette, vape pen, hookah)? □ Yes □ No

What form of other products? _____

How much tobacco do you use each day? _____ Have you used tobacco in the past? □Yes □No

Ever tried to quit? □Yes □No

Alcohol:

Do you drink alcohol? □Yes □No

What type of alcohol? _____ How much do you drink in a usual week? _____

When did you last drink? _____ When did you quit drinking? _____

How many times in the past year have you had 4+ drinks in a day if you're a woman, or 5+ drinks in a day if you're a man? _____

Substance Use:

In the past 12 months, hoe often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal Meth), hallucinogens, ecstasy/MMDA? □ Yes □ No

(Circle One): Daily or almost daily, weekly, monthly, less than monthly, or never.

Please list the following information about your family:

Year of birth:	**Major Illness (if applicable, cause of death)**	**Living/Deceased**	**If deceased, what age?**
Father _____	_____	_____	_____
Mother _____	_____	_____	_____
Siblings: Gender	_____	_____	_____
_____ □M □F	_____	_____	_____
_____ □M □F	_____	_____	_____
Children: Gender			
_____ □M □F	_____	_____	_____
_____ □M □F	_____	_____	_____

Family History:

Please check if any family members have had any of the following and who in the family had it. (Example: Allergies: Mother)

□Allergies_____
□Cancer _____
□High blood pressure
_____
□Alcoholism _____
□Diabetes _____
□Kidney disease _____
□Asthma _____
□Epilepsy _____
□Mental Health disorder

_____
□Bleeding tendency _____
□Heart disease _____
□Tuberculosis
_____
□Blindness _____

□Hearing loss
_____
□Stroke/CVA

_____
□Neurological disorder

_____

□Other (specify)
_____
_____

Please list the following information about your family:

	Father	**Mother**	**Siblings**	Children
Year of birth			□M □F □M □F □M □F □M □F	□M □F □M □F □M □F □M □F
Major Illness				
Living/Deceased				
If deceased, what age?				
(if applicable, cause of death)				

Please list below all the medications you are currently taking and who prescribed it:

Medications:	**Prescribing Doctor**	**Date**

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Promise Healthcare, dedicated to improving the health of the community through treatment, prevention, and education.

Promise Healthcare Notice of Privacy

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights:
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We may ask you make the request in writing.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record:

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
  - We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications:

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
  - We will say "yes" to all reasonable requests.

Ask us to limit what we use or share:

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out- of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information:

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you:

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
  - We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:

- You can complain if you feel we have violated your rights by contacting us using the information on last page of this notice, or:
  - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696- 6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We will not retaliate against you for filing a complaint.

Your Choices:
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.

- Share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Other Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you:

- We can use your health information and share it with other professionals who are treating you.
  Example: *A doctor treating you for an injury asks another doctor about your overall health condition.*
- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  Example: *We use health information about you to manage your treatment and services.*
- We can use and share your health information to bill and get payment from health plans or other entities.
  Example: *We give information about you to your health insurance plan so it will pay for your services.*

The examples used in this Notice of Privacy Practices are illustrations only and not meant to be a complete list.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues:

- We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research:

- We can use or share your information for health research.

Comply with the law:

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests:

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director:

- We can share health information with a coroner, medical examiner, or funeral director when an individual passes away.

Address workers' compensation, law enforcement, and other government requests:

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions:

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Federal law privacy protections and state law privacy protections

HIPAA generally does not preempt or override other laws that give people greater privacy protections. If any applicable state or federal law requires us to provide you with more privacy protections, then we must follow that law in addition to HIPAA.

Some types of health information may have additional protection under federal or state law. For example, some genetic test results, mental health records, HIV / AIDS test results, educational records, and federally assisted alcohol and substance abuse treatment programs are subject to special restrictions on our use and disclosure under various laws.

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/ understanding/consumers/noticepp.html

Changes to the Terms of This Notice:
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations:

This notice covers Promise Healthcare's services which includes:

- Frances Nelson Health Center
- SmileHealthy Dental Center
- Medicaid and Health Insurance Marketplace Outreach and Enrollment
- Promise Healthcare at the Community Resource Center
- Promise Healthcare at Community Elements
- SmileHealthy Mobile, Head Start & Education

If you have any questions or would like further information about this Notice of Privacy Practices, you can write or call Promise Healthcare's Privacy Officer:

Promise Healthcare

Privacy Officer| Alan Mendoza | amendoza@promisehealth.org

819 Bloomington Road |Champaign, IL 61820 | www.promisehealth.org | (217) 356-1558

Effective Date: 4/14/2021

Patients' Rights

As an individual receiving services through Promise Healthcare, you have the right:

- To receive services regardless of your age, race, color, sexual orientation, religion, marital status, gender, national origin or sponsors.
- To be treated with consideration, respect and dignity, including privacy treatment.
- To be informed of services available at our health center.
- To be informed of provisions for off-hour emergency coverage.
- To be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care.
- To receive an itemized copy of your account statement upon request.
- To obtain from our health center, complete and current information concerning your diagnosis, treatment and prognosis in terms you can be reasonably expected to understand.
- To refuse to participate in experimental research.
- To receive from your clinician, information necessary to give informed consents prior to the start of any nonemergency procedure and/or treatment. An informed consent shall include, as a minimum, the provision of information concerning the specific procedure and/or treatment, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting you to make a knowledgeable decision.
- To refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of this action.
- To voice grievances and recommend changes in policies and services to the agency staff, the administrator of the agency, or the Department of Health without fear of reprisal.
- To express complaints about the care and services and to have the health center investigate such complaints. Promise Healthcare is responsible for providing you or your designee with a written response within 30 days, if requested, indicating the findings of the investigation. The agency is also responsible for notifying you or your designee that if you are not satisfied by the agency response, you may complain to the Illinois State Department of Health's Office of Health Systems Management.
- To have the privacy and confidentiality of all information and records pertaining to your treatment at Promise Healthcare facilities.
- To approve or refuse the disclosure information of the contents of your medical record to any health care practitioner and/or health care facility except as required by law or third-party payment contract.
- To access your medical record.

Effective Date: 06/01/2021

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DISCLAIMER: As a federally qualified health center (FQHC), we are required to request the information below. We realize that this is very personal Information. Therefore, we want you to know your answers will be held in the strictest confidence. The information collected is used only as a total from our database, so it in no way identifies a specific individual or family. The information collected helps to shape future programs and services to be made available at our clinics as well as on local, state, and federal levels. Thank you for your participation.

Fill out this form to Register or Update your information as a Promise Healthcare patient – (*Expires in 1 year from date signed)*

Today's Date:	**Promise Healthcare Provider:**

Patient Information (Please Print):

Circle One: Miss Ms. Mrs. Dr. Mr.	**Last Name:**	**First Name:**	**Middle Name:**	**Suffix:** Circle One Jr. Sr. Other _____
Former Name:	**Preferred Name:**	**Social Security #:**	**Birthdate:**	**Sex Assigned at Birth:** Male Female

Billing Street Address:	**City:**	**State:**	**Zip Code:**	**Country:**	**County:**
Home Address (if different):	**City:**	**State:**	**Zip Code:**	**Country:**	**County:**

Home Phone:	**Work Phone:**	**Cell phone:**
Email Address:		

Gender Identity: (Circle One)	**Sexual Orientation: (Circle One)**	**Marital Status: (Circle One)**	**Patient Notification/Contact Preference *(Circle All that Apply):***
Female	Lesbian or Gay	Single	Phone Call – Home/Cell/Work/All
Male	Heterosexual (Straight)	Married	Text Message
Female-to-Male (FTM) *Transgender Male*	Bisexual	Legally Separated	Email
Male-to-Female (MTF) *Transgender Female*	Something else	Divorced	Patient Portal
Choose not to disclose	Choose Not to Disclose	Life Partner	Don't Call Home/Work
Other: _____	Don't Know	Widowed	Leave Message – Yes/No
		Decline to Specify	

Race: (Circle all that apply)		**Ethnicity: (Circle One)**	**Student Status: (Circle one)**
American Indian/Alaskan Native	Other Pacific Islander	Hispanic/Latino	Full Time
Black/African American	White	Not Hispanic/Latino	Part Time
Native Hawaiian	Asian	Unknown/Decline to Report	Not a Student
Decline to Report			

Preferred Language: (Circle All that Apply)

English	Italian	German	Tigrinya	Decline to Answer
Japanese	Mandarin Chinese	French	Burmese	Spanish
Sudanese	Other: _____			

Prompt Pay Discount:

It is the policy of Promise Healthcare to encourage patients to promptly pay for services; Promise Healthcare offers a 30% discount for the prompt payment of amounts due. Promise Healthcare considers prompt payment to be payment made on the date of service.

- This discount is offered to patients who ***do not have private health insurance*** are considered full-pay, self-pay patients.
- Payment is requested from the client at the time of service, and the flat rate discount is given, if the patient pays in-full for the visit.

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Person Responsible for Bill

Last Name:	First Name:	Middle Name:	Previous Last Name:
Social Security #	Date of Birth: / /	Relationship: ☐ Self ☐ Parent ☐ Life Partner ☐ Spouse ☐ Other: _____	
Street Address:	City:	State:	Zip Code:	Country:	County:

Employer Information

Employer Name:					
Employer Street Address:	City:	State:	Zip Code:	Country:	County:
Occupation:	Employment Status: (Circle One) Full Time Part Time Active Duty Retired Not Employed Self Employed	Work Phone:	Retirement Date: / /		

Emergency Contact / Next of Kin

Last Name:	First Name:	Relationship:	Phone Number:
Street Address:	City:	State:	Zip Code:

Insurance Information: Card MUST be given to Front Desk Representative and Co-Pay paid at Visit

Primary Insurance:
Medicare Medicaid Blue Cross Blue Shield Molina United Healthcare Other:

Name of Policy Holder:	Birthdate of Policy Holder: / /	Relationship:

Secondary Insurance:
Medicare Medicaid Blue Cross Blue Shield Molina United Healthcare Other: _____

Name of Policy Holder:	Birthdate of Policy Holder: / /	Relationship:

Housing and Worker Status

Homeless Status: (Circle One)	Migrant Worker Status: (Circle One)	Have you ever served in the Armed Forces: (Circle One)
Doubling Up Street Not Homeless Transitional Shelter Unknown Permanent Supportive Housing	Migrant Not a Farm Worker Seasonal Worker	No Yes

Sliding Fee Scale Discount Information and Purpose:

Promise Healthcare maintains a standard procedure for qualifying patients for sliding fee scale discounts for services provided. Sliding fee scale discounts are available to patients with all incomes at or below 200% of the federal poverty guidelines. Sliding fee scale discounts apply to all directly provided Promise Healthcare services, and for all in-scope services, provided by agreement by non-Promise Healthcare providers.

Purpose:

To reduce and/or eliminate financial barriers to care for medically underserved populations.

Sliding Fee Income Table 2021 - *Circle One Box*

# of Persons in Household	Household Income	Sliding Scale A Nominal Fee* $10 per visit	Sliding Scale B $25 per visit	Sliding Scale C $35 per visit	Sliding Scale D $45 per visit	100 % Full Pay
1	Annual	$0.00 - $12,880.00	$12,881.00 - $19,320.00	$19,321.00 - $22,540.00	$22,541.00 - $25,760.00	$25,761.00 +
	Per Month	$0.00 - $1,073.00	$1,074.00 - $1,610.00	$1,610.00 - $1,878.00	$1,879.00 - $2,147.00	$2,148.00 +
	Per Week	$0.00 - $ 247.00	$248.00 - $371.00	$372.00 - $432.00	$433.00 - $494.00	$495.00 +
2	Annual	$0.00 - $17,420.00	$17,421.00 - $26,130.00	$26,131.00 - $30,485.00	$30,486.00 - $34,840.00	$34,841.00 +
	Per Month	$0.00 - $1,452.00	$1,453.00 - $2,177.00	$2,178.00 - $2,540.00	$2,541.00 - $2,903.00	$2,904.00 +
	Per Week	$0.00 - $334.00	$335.00 - $501.00	$502.00 - $585.00	$586.00 - $668.00	$669.00 +
3	Annual	$0.00 - $21,960.00	$21,961.00 - $32,940.00	$32,941.00 - $38,430.00	$38,431.00 - $43,920.00	$43,921.00 +
	Per Month	$0.00 - $1,830.00	$1,831.00 - $2,745.00	$2,746.00 - $3,203.00	$3,204.00 - $3,660.00	$3,661.00 +
	Per Week	$0.00 - $421.00	$422.00 - $ 632.00	$633.00 - $737.00	$738.00 - $842.00	$843.00 +
4	Annual	$0.00 - $26,500.00	$26,501.00 - $39,750.00	$39,751.00 - $46,375.00	$46,376.00 - $53,000.00	$53,001.00 +
	Per Month	$0.00 - $2,208.00	$2,209.00 - $3,313.00	$3,314.00 - $3,865.00	$3,866.00 - $4,417.00	$4,418.00 +
	Per Week	$0.00 - $508.00	$509.00 - $ 762.00	$763.00 - $889.00	$890.00 - $1,016.00	$1,017.00 +
5	Annual	$0.00 - $31,040.00	$31,041.00 - $46,560.00	$46,561.00 - $54,320.00	$54,321.00 - $62,080.00	$62,081.00 +
	Per Month	$0.00 - $2,587.00	$2,588.00 - $3,880.00	$3,881.00 - $4,527.00	$4,528.00 - $5,173.00	$5,174.00 +
	Per Week	$0.00 - $595.00	$596.00 - $893.00	$894.00 - $1,042.00	$1,043.00 - $ 1,191.00	$1,192.00 +
6	Annual	$0.00 - $35,580.00	$35,581.00 - $53,370.00	$53,371.00 - $62,265.00	$62,266.00 - $71,160.00	$71,161.00 +
	Per Month	$0.00 - $2,965.00	$2,966.00 - $4,448.00	$4,449.00 - $5,189.00	$5,190.00 - $5,930.00	$5,931.00 +
	Per Week	$0.00 - $682.00	$683.00 - $1,024.00	$1,025.00 - $1,194.00	$1,195.00 - $1,365.00	$1,366.00 +
7	Annual	$0.00 - $40,120.00	$40,121.00 - $60,180.00	$60,181.00 - $70,210.00	$70,211.00 - $80,240.00	$80,241.00 +
	Per Month	$0.00 - $3,343.00	$3,344.00 - $5,015.00	$5,016.00 - $5,851.00	$5,852.00 - $6,687.00	$6,688.00 +
	Per Week	$0.00 - $769.00	$770.00 - $1,154.00	$1,155.00 - $1,346.00	$1,347.00 - $1,539.00	$1,540.00 +
8	Annual	$0.00 - $44,660.00	$44,661.00 - $66,990.00	$66,991.00 - $78,155.00	$78,156.00 - $89,320.00	$89,321.00 +
	Per Month	$0.00 - $3,722.00	$3,723.00 - $5,583.00	$5,584.00 - $6,513.00	$6,514.00 - $7,443.00	$7,444.00 +
	Per Week	$0.00 - $856.00	$857.00 - $1,285.00	$1,286.00 - $1,499.00	$1,500.00 - $1,713.00	$1,714.00 +

For each additional household member add:

$4,540.00 to Annual Income

$4,378.33 to Monthly Income

$87.31 to Weekly Income

Sliding Fee Scale is based upon total gross household income and the number of persons residing in the household.
Effective 03/01/2021

READ AND SIGN THIS SECTION

I, the patient or parent/guardian of this patient, have the legal responsibility and the right to obtain treatment and further:

- Understand this consent is good for one year from the date indicated below.
- Allow the health care Provider to give the treatment needed. This care may include but is not limited to:
  - Radiology to diagnose a problem
  - Taking samples of blood which may look for contagious diseases such as Hepatitis and HIV/AIDS
  - Taking samples of body fluids or body tissue
  - Giving medicine, immunizations and vaccines
- We will not discuss mental health, development disabilities, alcohol/drug abuse, genetics, or HIV/STDs/AIDS without an additional release form.
- Allow my Provider to treat in emergencies if it may save my/this patient's life or health.
- Agree that care at Promise emphasizes care coordination and communication into what we, as a team, deem best for the patient.
- Understand that I have the right to refuse any recommended treatment(s) that I do not agree with,
- **Understand that copay/payment in full is due at the time of service.**
- Understand Promise accepts Medicare, Medicaid, and most major commercial insurances.
- Authorize Promise Healthcare to release to Medicare/Medicaid/Insurance, the private health information necessary to process my/this patient's claim(s).
- Agree that Promise will file claim and complete the steps to collect insurance payment.
- Authorize Medicare/Medicaid/Insurance payment to be paid directly to Promise.
- Agree that if Medicare/Medicaid/Insurance doesn't pay the claim in full, **I am responsible for any remaining balance**.
- If patient copay and/or outstanding balance cannot be paid at time of service, and the nature of the visit is not non-emergency as determined by Promise triage policy, the appointment may be re-scheduled.
- Understand Promise will assess a fee for returned checks. After two returned checks, cash or debit/credit card will be the only acceptable means of payment.
- Agree to call at least 24 hours before the patients scheduled appointment to reschedule or cancelled. If calls are made in less than 24 hours, documentation will be made within the patient's chart.
- After **three NO-SHOWS,** patients will be placed on a walk in and wait status (except for same day appointments, children under the age of 2, and potentially a child under the age of 19 (Under the discretion of the Clinical Director).
  - A written copy of the No Show Policy is available to all medical patients.
- **For Pediatric Patients**: Illinois Immunization Registry (I-CARE): I-CARE, or Illinois Comprehensive Automated Immunization Registry Exchange, is a web-based immunization record sharing application developed by the Illinois Department of Public Health. The application allows public and private health care providers to share the immunization records of Illinois residents with other physicians statewide. If you refuse to share your child's immunization history to I-CARE, please let your in-take person know to obtain Opt Out of Registry Form.

Sign (Patient/Parent/Guardian):_____ Date: _____

Please agree you have received and read the Notice of Privacy Practices by signing below

Patient Signature:	Date:
Print Name:	Signature of Parent, Guardian, or Patient's Representative (if applicable):
Please describe your legal right to act on behalf of the patient:	

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with us. All complaints must be given in writing on the form provided by Promise Healthcare. To obtain a form, contact the Site Manager at (217) 356-1558 . You also may file a complaint with the U. S. Department of Health and Human Services Office for Civil Rights. *You will not be penalized for filing a complaint.*

promise healthcare

Promise Healthcare, dedicated to improving the health of the community through treatment, prevention, and education.

WHO CAN HAVE YOUR HEALTH INFORMATION?

Please fill out this form. It will tell us which family members and friends have your permission to haveyour health information.

Patient Name:	Date of Birth:

ABOUT THIS FORM:

- Let those listed below have information about your medical care of payment
- Informs those listed below or a disaster relief organization of your location, health or death

THESE PEOPLE CAN HAVE MY HEALTH INFORMATION:

1. Name:		Relationship to you:	
Phone #:	Street Address:		
City:		State:	Zip Code:
2. Name:		Relationship to you:	
Phone #:	Street Address:		
City:		State:	Zip Code:
3. Name:		Relationship to you:	
Phone #:	Street Address:		
City:		State:	Zip Code:

PLEASE SIGN HERE:

By signing below, I allow Promise Healthcare to talk about or release my health information with the people listed above.

Mark All You Approve:

☐ **All Information**

☐ **Billing Information** ☐ **Appointment Information** ☐ **Lab results** ☐ **Testing Results**

☐ **Treatment(s)** ☐ **Dental Services**

☐ **Other:** _____

***Please note: We will not discuss mental health, developmental disabilities, alcohol/drug abuse, genetics, or HIV/AIDS/STDs with an additional sign release form.**

Patient/Parent/Guardian Signature:	Today's Date:

Your permission expires in one year unless cancelled in writing.

Revised – Effective 04/14/2021